UNUMPROVIDENT

LONG TERM CARE

Underwritten by:
Unum Life Insurance Company of America
LTC Department – A206
2211 Congress Street, Portland, Maine 04122

State of Maryland

Long Term Care Insurance
Benefit Election Form
Policy #538579

Applicant Name (Last Name, First, Middle Initial)		Social Security Number __ __ __ - __ __ - __ __ __ __
Street Address	Employee Date of Hire __ __/__ __/__ __ __ __	Date of Birth __ __/__ __/__ __ __ __
City, State, Zip Code	Gender ☐ Male ☐ Female	Work Telephone # ( )
		Home Telephone # ( )

Complete the following only if applicant is the spouse of an employee:

Employee's Name	**Employee Social Security No.** __ __ __ - __ __ - __ __ __ __	**Employee Date of Birth** __ __/__ __/__ __ __ __	**Employee Date of Hire** __ __/__ __/__ __ __ __

Applicant Is:

☐ Employee *	☐ Employee's Parent or Grandparent	☐ Sibling *(minimum age 18)*	☐ Retiree
☐ Employee's Spouse *	☐ Spouse's Parent or Grandparent	☐ Child *(minimum age 18)*	☐ Retiree's Spouse

*** If you are an employee, or the spouse of an employee, please complete:**

Employee's Six Digit Agency Code (from payroll stub) ___ ___ ___ ___ ___ ___

Plans

(Check one)

☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 4**
• Long Term Care Facility • Professional Home Care	• Long Term Care Facility • Professional Home Care • Nonforfeiture	• Long Term Care Facility • Professional Home Care • Compound Inflation	• Long Term Care Facility • Professional Home Care • Nonforfeiture • Compound Inflation

Facility Monthly Benefit Amount

(Check one)

☐ 3 Years	☐ 6 Years

Facility Benefit Duration *(Duration of benefits may vary depending on where benefits are received.)*

(Check one)

☐ $2,500	☐ $3,000	☐ $4,500	☐ **$6,000 ****

** **All Active Employees & Newly Hired Employees – who enroll after the Guarantee Issue enrollment period or choose benefits over the Guarantee Issue limits will be required to fill out a medical questionnaire. All other applicants, including retirees must complete a Benefit Election Form Long Term Care Application (medical questionnaire) for any selection.**

If you are an Active Employee's Spouse your premium will be paid through the employee's payroll deduction, please sign below. Employee must sign below to authorize the employer to make the payroll deduction.
All other eligible family members or retirees will be billed directly by the insurance company.

Family members or retirees, how would you like to be billed? ☐ Quarterly ☐ Semi-Annually ☐ Annually

Caution: if your answers on this Enrollment Form are incorrect or untrue, we may have the right to deny benefits or rescind your insurance.

By signing below, you signify that you have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after your effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to your coverage. This information is contained in your kit.

Your Premium: $_____ ***(Transfer the premium amount from the calculation on the rate sheet.)***

_____	__ __/__ __/__ __ __ __	_____	__ __/__ __/__ __ __ __
Applicant's Signature	*Date*	*Employee's Signature*	*Date*

Spouses, sign and submit this form to the employee's employer. Other applicants, sign and mail to UnumProvident (address at top of page). You may want to make a copy for your records.

If you have questions about Long Term Care coverage, please call UnumProvident's toll-free number: 1-800-227-4165.